Medicaid Information Bulletin

April 2005

Web address: http://health.utah.gov/medicaid

TABLE OF CONTENTS

TABLE OF CONTINUED

BULLETINS BY TYPE OF SERVICE

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Medicaid Information

- **Salt Lake City area, call 538-6155.**
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05 - 36 Provider Manual: SECTION 1 Revised

SECTION 1 of the Medicaid Provider Manual has been updated. It is available on-line at http://health.utah.gov/medicaid/pdfs/SECTION1.pdf . Changes are on pages dated April 2005. Significant text changes are marked with a vertical line in the left margin. Marked changes include the following chapters:

- 1 - 2, Medicaid Program Requirements: a client's household income as Percent of the Federal Poverty Level.
- 4 - 8, Changing Health Plans
- 7 - 1, Determining Compliance with Standards
- 8 - 1, Healthcare Common Procedure Coding System (HCPCS)
- 9, PRIOR AUTHORIZATION, Item B
- 9 - 4, Prior Authorization Procedures, item D
- 11 - 4, Billing Third Parties
- 11 - 6, Medicare/Medicaid Crossover Claims
- 11 - 7, Filing Crossover Claims
- 11 - 9, Billing Medicaid
- 11 - 14, HIPAA Format for Professional Claims Submission [new chapter added]
- 11 - 15, Claim Corrections Through Re-submission [new chapter added]
- 12, MEDICAID INFORMATION, Electronic Mail Access to Medicaid Staff
- 13 - 2, Utah Medical Assistance Program [Chapter Removed]
- 13 - 7, Emergency Services Program For Non-Citizens, Steps to Seeking Payment for Services Provided to an Emergency Services Client

Minor changes not marked include changing all references to a Health Maintenance (HMO) to "health plan"; and changing all references to Health Care Financing Administration (HCFA), including the form HCFA-1500, to Centers for Medicare & Medicaid Services and CMS-1500. If you do not have access to the internet, please call the Medicaid Hotline at 801-538-6155 or 1-800-662-9651 to request a copy of the current SECTION 1. ☐

05 - 37 Crossover Claims

A Crossover Claim is a coordination of benefit claim for a recipient who has both Medicare and Medicaid eligibility. Covered services are based on Medicare scope of benefits.

Co-payments

No co-payment is required when service is covered through Crossovers.

Billing Crossovers Direct

Effective April 1, if a claim did not crossover from Medicare, providers can bill the claim directly to Crossovers. Medicaid prefers the usage of the electronic 4010 format. It is not necessary to submit an EOMB for $0 payment or denials. Complete the other payer payment information, including payer paid amount, patient liability and reason codes.

Submit to: HT000004-005 Utah Medicaid Crossovers

If billing a paper claim, COB instructions are available at www.health.utah.gov/medicaid . Claims will be returned if not in the proper format.

Chiropractic Services

Visits covered by Medicare are billed through Crossovers. Additional Chiropractic visits are covered through authorization by CHP and billed directly to Medicaid.

Non-covered or Denied Services

Non-covered or denied services by Medicare are not covered through Crossovers. Claims should be submitted to Medicaid. All rules and regulations of Medicaid apply. Non-covered Medicare services do not need to be billed to Medicare prior to submission to Medicaid.

When billing Medicaid directly, provide appropriate remark codes electronically or submit the Medicare EOMB as an attachment or Fax to Team 82 at the Office of Recovery Services (801-536-8513). ☐

05 - 38 Criteria for OB/GYN Procedures

The 2004 edition of InterQual Criteria has relaxed the requirement for a pregnancy test to positively rule out a pregnancy prior to approval for any endometrial ablation, hysterectomy, hysteroscopy, or hysteroscopy with D&C. The criteria requires that "Pregnancy and related complications must be excluded before surgery." Multiple choice of either pregnancy test, history of sterilization, or negative history of sexual activity can then be chosen to support the requirement. Since a negative pregnancy test is the only positive choice to assure that pregnancy is not present, Medicaid will continue to require written report of a negative pregnancy test before authorization will be given for any of the OB/GYN surgical procedures. ☐

05 - 39 Vision

Code V2513, contact lense, gas permeable, extended has been opened in the vision program for children and requires a prior authorization. ☐

05 - 40 Audiology

Beginning April 1, 2005, digital hearing aids are available to all ages in Traditional Medicaid. The pricing will change from $1400 for monaural to $500 for monaural. Binaural applications will be paid $1000. Pricing for analog hearing aids will remain at $500 for monaural and will raise to $1000 for binaural applications.

Opened codes:
V5030, Hearing aid monaural, body worn, air conduction
V5258, Hearing aid, digital, binaural, CIC
V5259, Hearing aid, digital, binaural, ITC
V5260, Hearing aid digital, binaural , ITE
V5261, Hearing aid, digital, binaural, BTE

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05 - 41 Medical Supplies

Opened codes each **requiring prior authorization.**

E0483, High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each.
E2402 LR , Negative pressure wound therapy, electric pump, stationary/portable.
A6550, Dressings set for negative pressure therapy for electric pumps, each,
A6551, Canister set for negative pressure therapy for electric pumps, each,
K0040, Adjustable angle foot plate
K0064, Zero Pressure Tube (flat free inserts), any size, each
K0075, Semi pneumatic caster tire, any size
K0602, Replacement battery for patient owned external infusion pump, silver oxide, 3V, each, limited to two per month.
K0604, Replacement battery for patient owned external infusion pump, lithium 3.6V, each/ Limited to three per month.
B4149, Enteral Formula, Blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and mineral, may include fiber, administered through an enteral feeding tube, 100 calories= 1 unit
B4158, Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories=1 unit
B4159, Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories= 1 unit
B4160, Enteral formula, for pediatrics, nutritionally complete calorically dense(equal to ro greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals may include fiber, administer through an enteral feeding tube, 100 calories= 1 unit
B4161, Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain Proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories= 1 unit

Opened codes

V2625, Enlargement of ocular prosthesis
V2628, Fabrication and fitting of ocular conformer (includes subsequent adjustments

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05 - 42 Oral Surgeon

Opened codes

Code 21215, Graft, bone, mandible is open as of January 1, 2005. This requires a prior authorization in order to receive reimbursement.

Oral Surgeon and Dentists

Supernumerary teeth can now be billed in accordance with the ADA tooth numbering system as follows:

Upper Right **Deciduous Teeth** **Upper Left**

Tooth #	A	B	C	D	E	F	G	H	I	J
Supernumerary #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Lower Right **Deciduous Teeth** **Lower Left**

Tooth #	T	S	R	O	P	Q	N	M	L	K
Supernumerary #	TS	SS	RS	OS	PS	QS	NS	MS	LS	KS

Upper Right **Permanent Teeth** **Upper Left**

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
"Super" #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Lower Right **Permanent Teeth** **Lower Left**

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	10	19	18	17
"Super" #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

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05 - 43 Emergency Only Billing

Required documentation supporting the medical emergent care for the Emergency Only Program should be submitted to Medicaid with the original claim. If the claim is sent electronically, utilize the attachment control number. FAX or mail the documentation including the attachment control number, provider name, Medicaid provider ID, recipient name and Medicaid recipient ID.

Medicaid pays a claim for labor and delivery for an Emergency Only client without documentation

If a remittance advice is received stating payment denied, FAX or mail to Medicaid a copy of the remittance advice, the medical records **specific to the case in question**, including reports and consultations, and any other documentation in support of the services as a medical emergency. DO NOT rebill the claim.

All information to be considered for review MUST be included in this initial submission. A second submission of any additional documentation must be submitted through the formal hearing process.

Refer to SECTION 1 in the General Information of the Utah Medicaid Provider Manual for more detailed information regarding the Emergency Only Program or Formal Hearing Rights.

Electronic Claim Submission address:
HT00004-001

Paper Claims Submission address:
Medicaid Operations
P.O. Box 143106
Salt Lake City, UT 84114-3106

FAX number for the Emergency Services Program:
(801) 536-0475

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05 - 44 CLIA codes

See the following updated list of CLIA codes and new manufacturers. Not all the codes listed are covered by Medicaid.
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05 - 45 Physician Service Codes, Clarification and Minor Wording Changes

ICD-9 CM Codes **v25.09** and **V25.9** are open to allow initial physician counseling in family planning during the evaluation and management service. However, a series of evaluation and management services to provide extensive education in family planning, natural or alternative contraceptive methods, genetic counseling, or infertility counseling is not a covered service.
Under Physician Manual Section 2, **Specific non-covered services: n.** Certain services excluded as family planning services: **7)**Prolonged educational and counseling services beyond and above those included in the initial evaluation and management service.

Under Physician Manual Section 2, **Covered Service**: **7.** Preoperative examination and planning are covered as separate services only in the following circumstances:
a. When the preoperative visit is the initial visit for the physician, and the **patient's severity of condition** requires significant additional time for evaluation to establish the diagnosis and determine the need for a specific surgical procedure beyond the amount of time normally included in the global surgical evaluation and management service.

Change to Psychiatric evaluation
The modifier 22 will be removed from code 99245 for psychiatric evaluation. The computer system has been adapted to recognize and approve services for authorized psychiatric evaluations without a modifier.
Modifier 25
It has been brought to our attention that the physician provider manual in several places asks the coder to use modifier 22 in place of modifier 25 for significant separately identifiable service within the evaluation and management (E&M) service. Modifier 22 is used with procedures and it is not an appropriate modifier with an E&M service. Therefore, following CPT guidelines sections suggesting use of modifier 22 will be changed to say modifier 25. As previously mentioned in the manual, modifier 25 requires medical record documentation. Some claims may have been paid in error without documentation review; these claims are subject to post payment review through Program Integrity. The policy related to the requirement for documentation with modifier 25 has not changed.
Under **Limitations**
3.D.1. Modifier 25 should only be used with the evaluation and management service to indicate significant separately identifiable evaluation and management services beyond those included within procedures completed on the same date. The service should be identified by unique ICD.9 CM diagnosis codes and supportive medical record documentation must be submitted for review to verify the service. Significant separately identifiable E&M Service will be the emphasis of the review to determine if both services are appropriate for payment.
Under **Coverage**
16. A prepayment review of the medical record documentation of the unusual circumstances will be completed by Medicaid professional staff and medical consultants. Delete sentence beginning "Supporting documentation . . .
23. Chemotherapy Administration Modifier 22 will be changed to modifier 25.

Modifiers 53 and 73
Modifiers 53 and 73 are paid at 50% of the fee schedule

Anesthesia

The Basic Value assigned to the anesthesia code includes the pre-operative and post-operative care. Medicaid does not reimburse for two Basic values on the same date of service. When a patient has to return to surgery on the same date for complications, the provider is instructed to add the additional time required for the second surgery to the primary anesthesia code.

Clarification of issues in CPT and Criterion

The codes 36468, 36470, 36471 are not a benefit as addressed in the manual CPT code list and varicose vein criteria #42.

Renumbering was done with criteria #5 when mandibular reconstruction was added as a criteria in October 2003. Septoplasty became criterion #5A and Mandibular reconstruction became criterion #5B. Renumbering also occurred with criterion #35 when the Ophthalmic Biometry criterion was added, Corneal topography became criterion #35A and Ophthalmic Biometry became criterion #35B.

Manual only corrections

Neonatal codes

The 2005 CPT Manual made age range changes to the critical care neonatal codes. The Provider Manual is now corrected to reflect the critical care neonate code age adjustment from day 30 - 31 days to 28 - 29 days of age.

B status or Bundled codes under the Correct Coding initiative

As per the October 2004, MIB, Medicaid is following the correct coding initiative edits for Anesthesia for Special Circumstance and after hours codes. Changes overlooked in the physician section and anesthesia section of the provider manual were made.

CPT and Hospital Surgical List Corrections

The CPT code 58662 was inadvertently left off the list and has been restored. The CPT code 58940 and 58943 required ICD9 CM code changes which have been made on the CPT and Hospital Surgical List.

Issues for Review

A determination has been made the Norwood Procedure will be opened subject to the similar prior authorization process used for transplants, effective January 31, 2005.

Prior Authorization

33619 Repair of single ventricle with outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (i.e. Norwood Procedure) Written Approval . . . . . Criteria #28

When a physician has a patient with a condition which they feel presents compelling evidence of medical necessity and the procedure is not covered, the provider may submit the case to Utilization Review Committee for review. The medical record information for the case, clinical evidence-based research related to the efficacy of the procedure, and a summary of why the physician thinks the particular case should be considered as an exception should be submitted for review for a coverage exception.

The code 36475 is not covered in Medicaid. Varicose vein surgery using radio frequency **or** laser method is considered investigational and therefore a non-covered service in Medicaid. Medicare under law can cover some investigational procedures in their clinical trials; Medicaid cannot cover investigational or cosmetic procedures. Providers completing radiofrequency or laser procedures using alternative or unlisted codes are subject to Program Integrity claim review with potential legal action and monetary penalties. Medicaid coverage on this issue is clearly outlined in Criteria #42.

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05 - 46 CPT Codes Covered

45386 Colonoscopy with dilation by balloon, one or more strictures
79005 Radiopharmaceutical therapy, by oral administration
91034 Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation
91035 . . . with mucosal attached telemetry pH electrode placement, recording, analysis, and instrumentation

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05 - 47 CPT Codes Non-Covered for Assistant Surgeon

Add 45386 to the list of **CPT Codes Non-Covered for Assistant Surgeon**. ☐

05 - 48 Criteria for Medical and Surgical Procedures, New Criterion #32 D Diaphragmatic/Electrophrenic Stimulator

The phrenic stimulator is used in patients with neurological damage affecting the muscles of respiration to improve respiratory function. Patients eligible for the device must meet the following criterion:

Coverage requires the patient meet all of the following conditions:
A. The patient has high quadriplegia at C-3 or above **OR** congenital alveolar hypoventilation syndrome
B. The patient is unable to breath independently without a respirator.
C. The patient has adequate diaphragm and lung function. Preoperative screening tests demonstrate lungs and diaphragm can sustain ventilation by electrical stimulation.
D. There are viable phrenic nerves.

Non-Covered
A. Respiratory insufficiency is temporary
B. Patient has another serious disorder which may affect nerve conduction such as multiple sclerosis, vascular disease, tumors, or diabetes with neurological sequella.
C. Treatment of Hiccups
D. Investigational for patients with chronic obstructive pulmonary disease.

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05 - 49 Criteria for Medical and Surgical Procedures, Clarification, #40 MRI Spine

MRI may be medically necessary for coverage if the patient has not responded to at least a three-month trial of conservative treatment. This includes appropriate physical therapy instruction and/or treatment. The physician may provide the physical therapy instruction, but there should be an outline in the medical record documentation of the initial evaluation, exercise review with the patient, and the physician's instructions for home therapy.

Documentation of the standard medical imaging procedures completed should be submitted with the request for prior authorization. An MRI is considered reasonable when:
1)standard medical imaging methods are inconclusive and surgery is anticipated
2)in an acute injury with neurological deficit
3)in chronic back pain when there is an acute exacerbation of signs and symptoms with neurological deficit.

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05 - 50 Child Health Evaluation and Care Program (CHEC) Services (Appendix B) Updated

Attention: Physicians

The Utah Medicaid Provider Manual for Child Health Evaluation and Care Program (CHEC) Services (Appendix B) has been updated as follows:

In Chapter 3-4, Mental Health Services, an expanded overview and definition of mental health screening to SECTION 2.

We have included the following new recommendations for the use of social emotional screening tools for infants 0-12 months:

- Ages and Stages Questionnaire (ASQ)

- Ages and Stages Questionnaire: Social Emotional (ASQ:SE)
- Parent's Evaluation of Developmental Status (PEDS)
- Temperament and Atypical Behavior Scale (TABS)

We have identified the requirements of an acceptable screening tool and we have outlined the protocols for the referral process for children with suspected mental health needs.

Do not bill the developmental screening separately.

The revised SECTION 2 is on the Internet. Look for the link to manuals at www.health.state.ut.us/medicaid. If you do not have Internet access, contact Medicaid Information for a copy of the revised CHEC Manual or use the Publication Request Form.

Should you have questions, you may contact Russ Labrum, CHEC Program Manager, at 801.538.6206 or rlabrum@utah.gov . ☐

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05 - 51 Speech and Physical Therapy in Home Health

To provide consistent guidelines for therapy services in Home Health, criteria have been developed for approval and review of Speech Language Therapy and Physical Therapy services in the home. The criteria has been added to the Home Health Manual SECTION 2, Page 13. A copy is attached to update your Manual. ☐

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05 - 52 Clarification of Home Health Code S9122, Home Health Aide Service

Clarification and Provider Manual changes have been made consistent with a special Medicaid Information Bulletin sent to Home Health Agencies in October 2004. HCPCS Code S9122 is designated as a Home Health Aide Service in the home per Hour. Medicaid identifies this service to be a supportive maintenance level of service for clients in an independent living situation with no care giver in the home to assist. These clients my require extensive assistance to get out of bed in the morning, into a wheelchair, prepared for the day and then returned to bed at night. Based on care needs included in the plan of care and lack of care giver availability, authorization can be given for service "units"(hours) not to exceed 4 units per day for code S9122. Payment for approved units will be equal in time to one visit per day in keeping with Medicaid policy. The agency providing care may divide these units between morning and evening as necessary to provide adequate patient care.
Changes have been made on the Home Health Procedure Code Grid, SECTION 2, Chapter 7, P29
A copy is attached to update your Manual. ☐

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05 - 53 Clarification of Home Health Code T1021, Skilled Home Health Aide Service

Clarification is also provided for HCPCS code T1021. This code is defined as **Skilled Home Health Aide** service in the home per visit. (A visit = 2 hours.) Three changes are made:

- Under limitations for code T1021, it is noted that this aide visit can be made on the same day as a brief visit made by a RN or LPN who visits to provide a service the aide can not provide. Brief service code T1003 is noted. IV therapy codes T1002 and Q0081 should be added to this exception list.
- Also added is the caveat that this skilled aide service may be authorized twice a day for clients with extensive nursing care needs
- The requirement that adaptive equipment must be used, is removed because special equipment may not be necessary in all medically necessary skilled care.

Code T1021 can also be used under **Supportive Maintenance** level of service where care needs have stabilized, general nursing care is needed, but there are care givers in the home limited in their ability to participate in the care. The approved Visit time may be applied in the plan of care to meet service needs.
Changes have been made on the Home Health Procedure Code Grid, SECTION 2, Chapter 7, P24.
A copy is attached to update your Manual. ☐

05 - 54 Hospice In-home Physician Services CPT Codes

Effective March 1, 2005, the Division of Health Care Financing is authorizing five new CPT codes for use by physicians when providing in-home services to Medicaid recipients who have elected the Medicaid hospice benefit. The five new CPT codes are in addition to the one CPT code currently authorized for use for physician in-home services to hospice patients and other Medicaid recipients who qualify under special circumstances. The new CPT codes are 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99350. Descriptions of the new CPT codes, limitations of their use for hospice patients only, and requirements for prior authorization are contained in SECTION 2 of the Physician Services and Anesthesiology provider manual and the Medical and Surgical Procedures provider manual. Additional information relating to CPT code 99349 is also presented in the Medical and Surgical Procedures provider manual. ☐

05 - 55 Attention: Mental Health Centers, Substance Abuse Treatment Providers, and Targeted Case Management Providers for the Homeless

In the Utah Medicaid Provider Manual for Targeted Case Management for the Chronically Mentally Ill, Chapter 2-1, Covered Services and Activities, for the service specified in #6, the qualifications of individuals who may perform this particular case management activity have been clarified.

In the Utah Medicaid Provider Manual for Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse, Chapter 5-1, Covered Services and Activities, for the service specified in #6, the qualifications of individuals who may perform this particular case management activity have been clarified.

In the Utah Medicaid Provider Manual for Targeted Case Management for the Homeless, Chapter 2-1, Covered Services and Activities, for the service specified in #6, the qualifications of individuals who may perform this particular case management activity have been clarified.

Providers will find attached the updated page(s) with this clarification. A vertical line in the margin is next to the text that has been changed.

Contact Merrila Erickson at 538-6501 or merickson@utah.gov if you have any questions. ☐

05 - 56 SECTION 2, PHARMACY MANUAL, Chapter 1-1, Legal References, Revised

SECTION 2 UTAH MEDICAID PROVIDER MANUAL: Pharmacy Provider Manual, Chapter 1-1, Legal References, on page 2 has been revised. The revision references the current Utah Statute that mandates the use of generic drugs within the Medicaid Pharmacy program.

For your convenience, below is the revised text for Chapter 1-1. The clarifications are underlined in the text.

1 - 1 Legal References

Utah Public Law SB 114 mandates pharmacists to substitute "A" rated generically equivalent drugs for a prescribed name-brand product when made available by manufacturers. The Division of Health Care Financing requires all pharmacies to dispense generically within the intent and guidelines listed in this law and under the conditions established.

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05 - 57 SECTION 2, PHARMACY MANUAL, Chapter 1-8.4, Maximum $15.00/month Co-pay, Clarified

SECTION 2 UTAH MEDICAID PROVIDER MANUAL: Pharmacy Provider Manual, Chapter 1-8.4, Maximum $15.00 a month Co-payment for Each Recipient in the Traditional Medicaid Plan, page 8, has been revised. The revision clarifies the cumulative nature of Medicaid prescription Co-pays, and explains the manner by which the system handles reversed claims.

For your convenience, below is the revised text for Chapter 1-8.4. The clarifications are underlined in the text.

4. Maximum $15.00 a month Co-payment for Each Recipient In the Traditional Medicaid Plan

Once a recipient has met an individual maximum co-payment of $15.00 a month for his or her prescriptions, Point of Sale will NOT indicate a co-payment is due. Medicaid will keep track of the cumulative number of prescriptions for a recipient with $3.00 co-payments. Once five prescriptions with $3.00 co-payments have been filled, Point of Sale will no longer indicate a $3.00 co-payment. Reversal of a previously filled prescription with a co-pay will require a refund of the co-pay to the individual, and will cause the next prescription filled for that recipient to be adjudicated with a co-pay.

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05 - 58 SECTION 2, PHARMACY MANUAL, Chapter 2, Coverage of Services, Revised; SECTION 2, PHARMACY MANUAL, Chapter 7, Non-Covered Drugs and Services, Deleted and Information moved into Chapter 2, Coverage of Services

SECTION 2 UTAH MEDICAID PROVIDER MANUAL: Pharmacy Provider Manual, Chapter 2, Coverage of Services, page 10, has been revised. The revisions re-organize the information contained in this chapter in order to relate the material more understandably. **Chapter 2-1** now contains the definitive "**Formulary**" information previously found in 2-5. **Chapter 2-2** now contains all the information regarding "Prescribed Legend Drugs" with subheading **2-2.A** detailing information about **Prescribed Legend Drugs**, and **2-2.B** providing information regarding "**Off label, Experimental and Investigational**" use of Drugs. **Chapter 2.3, Non-covered Drugs and Services** combines the information previously located in 2-5.A, Non-covered Drugs, with all the information previously found in Chapter 7, Non-covered Drugs and Services.
Prescribed Over-the-Counter Products information is now located under **Chapter 2-4,** and **Generic Preparations** is now found in **Chapter 2-5.** Chapter 7, Non-Covered Drugs and Services, page 34, has been deleted. The online version of the SECTION 2 Pharmacy Provider Manual on the Medicaid Website http://health.utah.gov/medicaid includes these revisions.

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05 - 59 SECTION 2, PHARMACY MANUAL, Chapter 3, Prior Approval, Corrected

SECTION 2, UTAH MEDICAID PROVIDER MANUAL: Pharmacy Provider Manual, Chapter 3, Prior Approval, page 13 has been corrected. The corrections are necessary due to the fact that the physician is in possession of all the necessary information for making a prior approval request (**SEE JANUARY 2005 MIB**). Consequently, the physician must be the primary initiator of a prior approval request. Nothing in this chapter would preclude a pharmacy from deciding to act as the intermediary for the request.

For your convenience, below is the revised text for Chapter 3. The clarifications are underlined in the text:

3 PRIOR APPROVAL

Prior Authorization (PA) confirms that services requested are needed and reimbursable by Medicaid, that they conform to commonly accepted medical standards, and that all less costly or more conservative alternative treatments have been considered.

Prior authorization falls into two categories.

1. Services or drugs beyond the designated limitations

2. Services or drugs specifically identified as requiring prior authorization

The physician requests the prior authorization in accordance with the requirements stated on the Drug Criteria and Limits List. If any exception is noted, Medicaid requires the physician to obtain prior authorization in writing or by telephone in advance of the date of service. Nothing in this chapter would preclude a pharmacy from deciding to act as intermediary for the request, should they choose to do so. Products which require prior approval are on the Drug Criteria and Limits List with a description of the type of approval required and the criteria. The list may be amended by Medicaid Information Bulletins.

Prior authorization for a pharmaceutical is client specific, pharmacy specific, and product specific.
Prior authorization cannot be transferred to another pharmacy, to another product, to another strength of a previously authorized product, nor to another client. Refer to Chapter 3 - 2. Prior Authorization Is Provider specific.

3 - 1 Fee-for-Service Clients

Prior authorization requirements for pharmacy services apply to ALL fee-for-service clients, defined in Chapter 1 - 6, even though the client may be enrolled in a managed care plan which provides other types of health care services.

NOTE: Medicaid staff make every effort to ensure information provided is accurate. However, obtaining a prior authorization number does not ensure that the client is eligible for Medicaid on the date of service.

3 - 2 Prior Authorization Is Provider Specific

When a prior authorization is issued, the prior authorization number includes the pharmacy's Medicaid Provider Identification Number. The authorization number is valid only for the pharmacy provider filling the prescription. It is not transferrable to another pharmacy provider, including another store in the same chain. For example, prior authorization given to ABC Pharmacy #00 for John Doe for growth hormone cannot be used by XYZ Pharmacy nor by ABC Pharmacy #99.

Claims submitted for refills which require prior authorization can be paid only when the prior authorization number for the drug matches the provider number on the claim. Claims will be denied when the prior authorization number does not match the provider number. Claims submitted through the Medicaid Point of Sale payment system which deny for this error reason will state: "Claim submitted does not match prior authorization."

If the prescription is transferred to a different pharmacy, the existing prior approval (PA) must be terminated. The new pharmacy can then request its own PA for the remaining doses. The new pharmacy must obtain all information and documentation required for the PA. It may either obtain this from the pharmacy with the original PA or from the prescriber. Medicaid will assign a new PA number with the original end date for the residual doses. The second pharmacy cannot start the prescription with a new number of doses or a new time span.

3 - 3 Prior Authorization Process

1. A physician may request prior approval by telephone supplying identified information specified on the Drug Criteria and Limits List, or the physician may initiate and complete a written request for Prior Approval when necessary. The prescriber furnishes information to justify the need and may submit it either by mail or by Fax. **Request for renewing a prior approval must contain justification, along with any additional information required. Do not refer only to the previous prior approval number.**

a. Written Prior Authorization

Mail written requests to:

MEDICAID PRIOR AUTHORIZATION
P.O. BOX 143103
SALT LAKE CITY UT 84114-3103

b. Fax Number

Prior authorization requests may be faxed to **(1-801) 538-6382**, attention "Prior Authorizations"

c. Telephone Prior Authorization

Call Medicaid Information, then follow the telephone menu prompts.

In the Salt Lake City area, call **538-6155**

Call toll-free in Utah, Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado **1-800-662-9651**

From all other areas **1-801-538-6155**

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05 - 60 SECTION 2, PHARMACY MANUAL, Chapter 4-3, Controlled Substances, Reference Added

SECTION 2, UTAH MEDICAID PROVIDER MANUAL: Pharmacy Provider Manual, Chapter 4-3, Controlled Substances, page 17, has a reference added. Reference is made to the specific limits for Schedule II and III analgesics in the Drug Criteria and Limits List included with the attachments for the Manual, and to Chapter 4-9, Limits on Certain Drugs.

For your convenience, below is the added text for Chapter 4-3. The additions are underlined in the text:

Schedule II and III controlled substance analgesics, and Schedule II long acting analgesics have specific limits as described in the Drug Criteria and Limits List included with this manual (see also Chapter 4-9, Limits on certain drugs).

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05 - 61 SECTION 2, PHARMACY MANUAL, Chapter 4-4, Brand Name Drugs and Override, Clarified

SECTION 2, UTAH MEDICAID PROVIDER MANUAL: Pharmacy Provider Manual, Chapter 4-4, Brand Name Drugs and Override, page 17, has been clarified. Important information has been highlighted, and the example given in this section has been deleted due to ambiguity. ☐

05 - 62 SECTION 2, PHARMACY MANUAL, Chapter 4-5.3, Drug Recycling Program, Deleted

SECTION 2, UTAH MEDICAID PROVIDER MANUAL: Pharmacy Provider Manual, Chapter 4-5.3, Drug Recycling Program, page 18, has been deleted (**See January 2005 MIB**). ☐

05 - 63 SECTION 2, PHARMACY MANUAL, Chapter 4-6, Compounded Prescriptions, Updated

SECTION 2, UTAH MEDICAID PROVIDER MANUAL: Chapter 4-6, Compounded Prescriptions, page 19, has been updated. This update reflects current programming in place in the Medicaid System (**SEE JANUARY 2005 MIB** for explanation). ☐

05 - 64 SECTION 2, PHARMACY MANUAL, Chapter 5-2, Drugs for Schizophrenia, Updated

SECTION 2, UTAH MEDICAID PROVIDER MANUAL: Chapter 5-2, Drugs for Schizophrenia, page 22, has been updated. This update removes a specific policy referring to Clozaril generics, and adds an addition of a notice regarding the contractual engagement of Comprehensive NeuroScience (CNS) to evaluate the usage of atypical anti-psychotic drugs in the Medicaid program, and the nature of CNS' activities. ☐

05 - 65 SECTION 2, PHARMACY MANUAL, Chapter 5-6, Anti-Ulcer Drugs, Revised

SECTION 2,UTAH MEDICAID PROVIDER MANUAL: Chapter 5-6, Anti-Ulcer Drugs, on page 24, has been revised. This revision deletes the requirement for using the Medicaid Anti-Ulcer Drug Prescriptions Form, and removes the table of package sizes. ☐

05 - 66 SECTION 2, PHARMACY MANUAL, Chapter 5-15, Schedule II Narcotic Analgesics, Revised. Chapter 5-18, Actiq and Long Acting Narcotics, moved to Chapter 5-15

SECTION 2, UTAH MEDICAID PROVIDER MANUAL: Schedule II Narcotic Analgesics, has been revised. This revision

moves the information from Chapter 5-18 into Chapter 5-15, and creates Subheading A- Actiq, Long Acting Narcotics and Methadone, and Subheading B- Short Acting Narcotic Analgesics. The information from the two Chapters is condensed and Chapter 5-18 has been deleted.

For your convenience, below is the revised text for Chapter 5-15:

5 - 15 Schedule-2 Narcotic Analgesics

The DUR Board has restricted select schedule-2 narcotic analgesics effective 10/1/03. Those restrictions are:

A. **Actiq , Long Acting Narcotics and Methadone**

Actiq® (fentanyl citrate) lozenge will be covered **only** for diagnoses of malignant neoplasms, carcinoma in situ, or neoplasms of unspecified nature. An absolute cumulative limit of 120 units per any 30 days is maximum amount covered. Prescribers must write the appropriate ICD.9 Code (first four digits) on the prescription.

For chronic non-malignant pain, the following long acting and methadone formulations are restricted to maximum quantities of:

Morphine sulfate long acting- 90 capsules/tablets per any 30 day period
Duragesic up to and including 75mcg patches - 15 patches per any 30 day period
Oxycodone long acting - up to 90 tablets in any combination per any 30 day period
Methadone - 150 tablets per any 30 day period

Duragesic 100mcg is not covered for chronic non-malignant pain.
Physicians may petition the DUR Board for a patient specific override exceeding theses guidelines.

For clients with severe progressive malignant neoplasms, carcinoma in situ, or neoplasms of unspecified nature, end stage AIDS, or Paget's Disease, an override may be gained by the physician simply by writing in the an appropriate ICD.9 code on the prescription, otherwise large quantities will deny. The pharmacist must enter that code into the diagnosis field when processing each claim.

No therapeutic duplication is allowed for the long acting narcotics.

B. Short Acting Narcotic Analgesics

Short acting generic formulations (except methadone) are not affected by this policy.

Narcotic/Acetaminophen combinations (regardless of Schedule) are limited to 180 units per any 30 day period.

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05 - 67 SECTION 2, PHARMACY MANUAL, New Chapter 5-19, Levothyroxine Products, Added

SECTION 2, UTAH MEDICAID PROVIDER MANUL: Chapter 5-19, Levothyroxine Products, a new chapter, has been added to the Manual. This chapter and the table included, describe the new FDA Ratings for levothyroxine products and how they will affect the generic usage of these products in the Medicaid program.
Attention must be given to proper generic substitution now that these products have equivalency ratings.

For your convenience, below is the text for Chapter 5-19:

5 - 19 Levothyroxine Products

Effective July 28, 2004, therapeutic ratings for levothyroxine products were updated in the FDA Orange Book. The FDA has, for the first time, assigned multiple therapeutic ratings to the same product. Many of these products have been given a "three-character code" (AB1, AB2, or AB3), and only drugs with the same three-character code are considered to be therapeutically equivalent and therefore substitutable.

State and Federal regulations require that generic branded drugs be dispensed whenever such an equivalent is available. This presents a potentially confusing situation where attention must be given to the appropriate selection of product when prescriptions for levothyroxine are involved.

The FDA has provided the following chart as a guide:

Trade Name	Labeler	TE Code
UNITHROID	STEVENS J	AB1,AB2, AB3
LEVOTHYROXINE SODIUM	MYLAN	AB1, AB2, AB3
LEVOXYL	JONES PHARMA	AB1, AB3
SYNTHROID	ABBOTT	AB2
LEVO-T	ALARA PHARM	AB2, AB3

Accordingly, prescriptions dispensed for levothyroxine products would require the use of the appropriate generic equivalent product unless medical necessity is demonstrated as per established Medicaid guidelines. (See section 4-4)
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05 - 68 SECTION 2, PHARMACY MANUAL, PHYSICIAN MANUAL, Drug Criteria and Limits Lists, Revised

SECTION 2, UTAH MEDICAID PROVIDER MANUAL: Pharmacy Provider Manual/ Physician Services Provider Manual, Drug Criteria and Limits List, the attachment to these Manuals has been updated and revised. This revision updates the Drugs with Limits table for drugs with cumulative quantities, moves information for drugs with limits incorrectly located in the Prior Authorization tables into the Drugs with Limits table, eliminates duplicated Prior Authorization (PA) Criteria information (such as for Lovenox), and adds the PA Criteria for Synagis and Over-Active Bladder Anti-Spasmodics Long Acting Formulations. Lactulose and Nicotine Replacement Therapies and Zyban no longer need a PA; that information has been deleted. Prior Approval Criteria for supplemental Tryptans (5-HT_1 agonists) doses above the cumulative limit of nine per month is no longer pertinent and is deleted. In addition, because seven or more prescriptions per month per client (**SEE January 2005 MIB**) triggers a Drug Utilization Review, the Prescription Limit Table at the end of this section has been removed. ☐

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05 - 69 SECTION 2, PHARMACY MANUAL, OTC List Updated and Included with Attachments

The Medicaid list of Over the Counter (OTC) Drugs covered has been updated and will be included with future manuals.
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05 - 70 Methadone and Long-acting Opioid Analgesics Therapeutic Duplication Not Allowed

The Drug Utilization Review Board has determined that duplicating therapies between Methadone and other Long-Acting Opioid analgesics will not be allowed under Traditional, Non-Traditional, and PCN programs, effective April 1, 2005. Overlapping claims utilizing both therapies will deny for payment. ☐

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05 - 71 SECTION 2, PHARMACY MANUAL, Chapter 5-16, NSAIDS/Cox-2 Agents, Updated

SECTION 2, UTAH MEDICAID PROVIDER MANUAL: Chapter 5-16, NSAIDS/Cox-2 Agents, page 27 has been updated. This update removes Vioxx from the list of available agents. ☐

On-Line (Internet) Address for Medicaid: http://health.utah.gov/medicaid
Please make sure that any Medicaid bookmarks that you have are the new Medicaid Internet address shown above. The old web site is not being kept up to date, and it will be discontinued in late 2004. The old Medicaid Internet address was printed in many Medicaid documents. The address will be corrected when the document is updated. ☐